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POSITIVE AND NEGATIVE ASPECTS OF EXPOSURE TO RACISM AND TRAUMA: RESEARCH, ASSESSMENT AND TREATMENT IMPLICATIONS

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Many clinicians and researchers do not routinely inquire about possible exposure to race-related stressors, such as racial discrimination or assault that occurs solely or primarily because of the client's racial status or appearance. Exposure to stressful and traumatic race-related experiences may be a critical etiological factor in a client's presenting problems. Also, potentially positive aspects of race-related experiences may help to both counter the impact of traumatic exposure and contribute to successful coping.

The DSM, Culture, and Race

The DSM-IV TR (1) includes brief but very limited narrative mention of cultural factors in the assessment of psychiatric symptoms and disorders. There also is an appendix with both an "Outline for Cultural Formulations" and a "Glossary of Culture-Bound Syndromes." The glossary has been criticized as unsystematic, arbitrary and incomplete (2). It is curiously sparse in specifying distinctly regional or ethnic culture-bound syndromes characteristic of various population groups in the United States. Also, it slights any attention to factors of racism (3).

Furthermore, there is almost a complete absence in the DSM-IV-TR of considering the possible etiological or environmental role of race-related stressors and traumas. The author has not found the words "racism" or "racist" mentioned anywhere in the DSM-IV-TR, and the (generic) word "discrimination" is used once under "problems related to the social environment," Axis IV (1, p. 31). No race-related examples are listed among the many factors described under the various V-code problem areas, and the "Glossary of Culture Bound Syndromes" does not include any examples of race-bound syndromes as applied to the racial minority experience. For example, race-specific syndromes might include "race-based assault," "race-hate speech,"and "racist environment"(3). The omission of any mention of race-specific stressors or trauma is particularly glaring among the approximately 16 different environmental stressors mentioned in the text of Adjustment Disorder or the approximately 36 stressors in the texts of the acute and post-traumatic stress disorders.

Other Selected Literature Review

The literature on the relationship between racism and psychiatric symptoms is sparse but revealing. Perhaps the benchmark study of this subject found that exposure to racial discrimination accounted most significantly for 7.5% of the variance in the symptoms and distress of Blacks (4). Klonoff, Landrine and Ullman (5) reported that racial discrimination contributed most significantly, accounting for 15% of the variance, in symptoms reported among 520 Black adults. Other studies also describe the outcome of exposure to racism (6-15). Clark, Anderson, Clark & Williams (16) conducted an extensive review of the literature; they postulate a biopsychosocial model for systematic study of the effects of perceived racism among African Americans on psychological and physiological health outcomes. Mostly they describe negative physical health outcomes, as well as several psychological stress responses that may follow perceptions of racism (i.e., anger, paranoia, anxiety). However, there is no mention of either PTSD per se or any of the psychological literature on trauma.

Two of the very few edited works on cultural factors and PTSD have a heavy ethnocultural emphasis, and pay minimal if any attention to factors of racism per se. There are only three chapters in the collection of international contributors in Marsella, Friedman, Gerrity and Scurfield (17) that substanially discuss racism and its relationship to PTSD: racism as traumatic

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stress among African Americans (18), the pervasive impact of cumulative trauma on American Indian people (19), and the intersecting of race and gender (20). While the writings in Nader, Dubrow and Stamm (21) elaborate on cultural differences in the treatment of trauma and loss, they offer almost no commentary regarding race and racism.

The social work literature includes a number of writings that describe ethnoculturally-sensitive approaches to assessment and treatment (22-27). However, almost no attention is paid to specific discussion of the potential impact of race-related experiences per se.

While PTSD prevalence estimates 15 years after the war have been reported at 13.7% for White Vietnam Veterans (VNVs) (28), the literature on combat-related PTSD consistently documents elevated levels of psychopathology among ethnic minority veterans (29). This rate was significantly higher for Hispanic (27.9%) and African American (20.6%) VNVs. Laufer, Gallops & Frey-Wouter (30), Parson (31) and Allen (32) postulated that it was the differences in race or ethnic experiences among VNVs that explained such different rates. The Matsunaga Vietnam Veterans Project reported elevated rates of lifetime prevalence of PTSD among Southwest (45.3%) and Northern Plains (57.2%) American Indians and Native Hawaiian (38.1%) VNVs (33). Exposure to traditional combat stressors and pre-military risk factors only partially accounted for the elevated findings among ethnic minority veterans in these studies.

Unfortunately, neither the NVVRS or Matsunaga studies, or any other published results of larger scale studies of war-veterans has included items that systematically or specifically inquire about exposure and the possible impact of race-related experiences. To explore the possibility that such exposure might be a contributing or primary explanation, a recently completed research study conducted a detailed inquiry about possible exposure to race-related stressors by Asian American Vietnam veterans (34-35). A 33-item Race-Related Exposure Scale was validated. Also, while there was a significant association between combat exposure and both PTSD and other psychiatric symptoms, by far the strongest association was exposure to race-related stressors. Thus, is exposure to race-related stressors an important and previously unmeasured factor that is at least a partial explanation for the elevated findings of PTSD and other psychiatric symptoms among ethnic minority veterans? Are the findings by Loo et al (35) unique to Asian American Vietnam veterans? Root and Scurfield are conducting a VA-funded study (36) of African-American VNVs to adapt the Race-Related Exposure Scale developed for Asian American VNVs.

The U.S. Department of Defense conducted an Equal Opportunity Survey (EOS) (37). The EOS reported that exposure to and negative impact from negative race-related experiences is a significant current problem among members of the U.S. Armed Forces, especially but not limited to minority personnel. While the outcome measures utilized in this study were fairly simple and not specific to PTSD, the findings provide empirical evidence that exposure to race-related stressors is a present-day problem in the Armed Forces.

Finally, the absence of the study of racism as a risk factor in PTSD research studies is reflected in the comprehensive overview of risk factors for PTSD recently completed by Halligan & Yehuda (38). It is mentioned that the higher risk for PTSD among ethnic minorities has been identified as a risk factor in some studies, but that other studies indicate that ethnicity may be more of a predictor of exposure to trauma. However, once again the stressor of exposure to racism per se (as distinct from ethnicity status) is not identified as a factor that was specifically measured as either a risk factor or a predictor of exposure in any of the studies reviewed.

Conceptualization of race-related experiences

Race-related experiences can be defined as experiences that occur solely or primarily because of one's racial status and/or race-based physical appearance. Such exposure could be considered as a possible environmental stressor in the etiology of the adjustment and stress disorders (for a more complete discussion of several such factors, see 39-40).

Distinction between race and ethnocultural identification and heritage

The term "race-related" refers primarily to those more or less predominant and genetically inherited physical characteristics which, in various Western societies, have historically formed the basis for definitions of "race." Typically, such definitions center upon selected aggregates of characteristics such as skin color, facial features, and hair texture. In addition to physical features, various sociopolitical definitions of "race" include a number of other putatively distinguishing human attributes (39-40).

One must also be attentive to potentially important distinctions between racial and ethnocultural heritage and identity. Ethnocultural heritage refers to those background characteristics (sometimes including, but usually not limited to, racial heritage) which significantly influence the individual's sense of self and cultural identity. Such background characteristics include national origin, cultural traditions, language(s), rituals, and religious or spiritual beliefs and practices. Racial groups almost always will contain sub-groupings that are ethnoculturally

heterogeneous, i.e., the racially "Black" U.S. population is comprised predominantly of African-Americans born and raised in this country, but also includes substantially diverse ethnocultural communities from other countries such as Jamaica, Haiti, Cuba and Brazil.

Course or onset

The nature of exposure to race-related experiences may have been: (a) discrete and markedly memorable events, single-incident or repetitive; (b) more covert or subtle exposure; or (c) cumulative/repetitive over a period of time. The concept of insidious exposure is very important — a more chronic, pervasive type of exposure to years of racist-oriented attitudes and behaviors; however, no one episode may be sufficient to meet the DSM-IV TR adjustment and stress disorder diagnostic criteria (20, 39, 40-41,44).

Obstacles to considering race-related experiences in clinical and research settings

It is my clinical and research experience that in the absence of specific inquiry about possible exposure to race-related stressors, it is likely that race-related issues will not be identified or meaningfully discussed. The lack of routine, in-depth consideration and discussion of race-related experiences by most researchers, clinicians or clients renders it difficult to definitively rule-in-or-out the role that race-related experiences may have in adjustment or stress disorders or other presenting symptomatology. There are several possible obstacles to adequate attention to race-related experiences (39-40, 44).

Obstacles to Clinical or Research Inquiry About Race-Related Experiences

1. Lack of conceptual clarity and specificity of the potential clinical significance of discrete or cumulative exposure to race-related experiences.

2. Discomfort due to difference in racial heritage of client and clinician/researcher.

3. Discomfort due to a minority client also being in minority status in a therapy group.

4. Preoccupation by both the client and clinician/researcher with more commonly discussed traumatic stressors.

5. The emphasis on acute and shorter-term interventions, and the managed care limit on the number of reimbursable treatment sessions.

A paucity of research inquiry about race-related experiences is due in part to (a) the lack of recognition of the role that such might play in adjustment or stress disorders, (b) a preoccupation by either or both the clinician/researcher and client/participant with more commonly discussed stressors such as exposure to death and dying, traumatic physical assault or injury, and (c) the lack of validated instruments to assess this factor. Also, there may be a reluctance on the part of the client and/or the clinician to discuss sensitive race-related experiences when they are of different racial heritages, or when the agency is very under-represented in terms of having ethnic minorities on staff. Another obstacle is when an ethnic minority client also is in a minority status in a treatment group or when the group members consist primarily or solely of persons who are of the same race as the perpetrator of race-related experiences. Finally, there is the increasing emphasis on acute and shorter-term interventions, along with the managed care limits on the number of reimbursable sessions. The corresponding decrease in longer-term therapeutic relationships makes it quite difficult to have sufficient "relationship-building sessions" prior to initiating discussion of extremely sensitive race-related experiences.

Indicators to Conduct a Race-Related Assessment

1. When the client's presenting problems indicate race-related experiences.

2. When the client is of a clearly identifiable ethnocultural or racial minority group.

3. When the ethnic minority client previously or currently lives in a community in which he/she was in a clear ethnocultural or racial minority status.

4. When the clinician and client are of different racial backgrounds

5. When the client is willing to have such a discussion.

The client may report a presenting problem that is clearly related to a race-based stressor, such as having been the victim of a race-based assault. The reality of the prevalence of racism in all sectors of our country and internationally makes it a reasonable assumption that someone of a racial minority status has been both exposed to and significantly impacted by at least some race-related attitudes and behaviors. Also, unless a strong mutual trust has developed over time between the client and clinician,

one must assume that most clients will be reluctant to initiate a discussion of very sensitive race-related experiences especially if the client and clinician are of different racial backgrounds and/or the client does not have any reason to believe that the clinician is genuinely interested in, knowledgeable about or sensitive to race-related dynamics and issues. Finally, there is the possibility that the client feels too vulnerable or ambivalent to even discuss exposure to race-related experiences with a clinician or researcher.

Interview Guide to Assess Race-Related Experiences

The extent and depth of inquiry about race-related experiences will depend on the nature and urgency of the client's various presenting problems and the realities of the agency setting.

Inquiry about exposure to race-related stressor(s)

The clinician/researcher must directly ask clients about exposure to each of the following aspects of race-related stressors (34, 39-40, 44). One aspect to consider is direct experiences of racial prejudice and stigmatization, e.g., the client is the direct recipient, victim or target, and/or is present to witness or observe negative race-based attitudes and behaviors directed towards others. The second dimension is exposure to a racist environment in which racist attitudes or behaviors are not directed personally against the client, but are directed against others who are of the same race as the individual.

The client may have been exposed to race-related stressors along a continuum of severity. Exposure to relatively moderate race-related stressors could fit the stressor criterion for an Adjustment Disorder, i.e., the client is subjected to negative race-related behaviors and attitudes that clearly communicated to the client that he/she was "unwanted" or otherwise considered to be negative due to his/her racial status or appearance. A client may have been exposed to more severe race-related stressors that could fit the stressor criterion for a stress disorder, i.e., serious race-based verbal threats or physical assault against oneself or others.

There is the possibility that the race-related stressor(s) may fall "in-between" the extremes of severity, i.e., the client has been exposed to veiled or ambiguous race-based taunts or insults, or such comments are couched "as a joke." Clinical judgement is required to determine if such stressors fit more within the stressor criterion of adjustment versus stress disorders. On the other hand, the race-related stressors may not easily fit the stressor criterion for an adjustment or a stress disorder, i.e., the cumulative impact of "insidious exposure" to a series of negative race-related stressors such as discriminatory policies of community institutions and social organizations, none of which are overt, discrete singular events.

Inquiry about the impact of exposure to race-related stressor(s)

If there appears to have been a race-related trauma that has had a negative impact on the client, further inquiry about the core symptoms of PTSD are warranted. Has the client been experiencing intrusive and recurrent reliving symptoms of the experience? Let's take the example of exposure to race-related stressors by minority U.S. soldiers in Vietnam. There was a common statement I have heard many times from minority soldiers in clinical interviews: *"There wasn't any racism out in the bush, but there sure was back in base camp."* This seemed to be particularly true in the latter stages of the war, and following the assassination of Martin Luther King (47).

One African American Vietnam veteran who was the victim of a race-based taunting reported that. while in a latrine, four White soldiers began verbally taunting and threatening him. They called him such racial slurs as "nigger" and "brillo head" and dared him to do anything about it. Out numbered, he felt threatened for his physical safety, and did not say anything back to the four White soldiers. They laughed and sneered at him and finally let him leave the latrine. During the course of treatment, we explored the following questions: Did he experience tbat incident as terrifying and did he feel helpless? Did he or does he have involuntary mental images that intrude during the day that trigger his re-experiencing this event, e.g., whenever he is in a public bathroom that is then entered by several white persons? Are there stigma-based feelings and/or cognitions of shame and guilt, i.e., "standing out negatively" due to one's race? Is there evidence of avoidance or denial to try not to be overwhelmed by feelings and memories of the incident? For example, since the latrine incident, has he been particularly wary of going into a public restroom? Does he avoid talking about the incident with anyone? Has he possibly suffered a bicultural conflict or tension because he internalized the incident as demonstrating that he was cowardly in not responding? Finally, was or is there a presence of significant physical arousal symptoms that were not present or were much milder prior to the latrine incident, i.e.,has he become hypervigilent to an extreme degree; has he had subsequent marked trouble concentrating?

One must also consider yet another possible impact. The victim may have retaliated by becoming a perpetrator of race-related actions directed towards persons of other races. Such an aggressive reaction, especially if accompanied by subsequent anti-social acts that are justified "because I was unjustly victimized racially," may reveal underlying characterological personality traits.

Inquiry About Race-Related Strengths and Coping

The client may have been able to make something positive out of traumatic exposure to race-related stressors. From a "strength's perspective" (48), potential positive impact includes the development of remarkable "positive" attitudes

and bevaviors (49-52). Internal fortitude, increased resolve, a higher tolerance threshold and increased pride in one's racial heritage are possible (39-40). Johnson (53) and Powell-Johnson (54) emphasized that many African-American children develop self-inoculating and other coping strategies to better manage problems in a racist milieu. There may have been an elevation of self-pride about one's racial heritage or an enhanced commitment to learn more about the history and culture of one's racial heritage. The client may have assumed a positive leadership or initiator role, i.e., planning or hosting minority recognition activities. All such positive benefits may help to mitigate and transcend negative effects.

Also, does the client have a rich or significant history of positive race-related experiences? Such may at least partly account for being able to mitigate or transform negative exposure to positives or strengths. Have there been experiences when the client's racial heritage has been a source of pride, strength, or other positive impact, i.e., being accepted racially at a social activity? Have there been race-related experiences that reinforced one's racial status/heritage, i.e., receiving verbal race-based praise or support from a parent, relative, peer, teacher or clergy? Have such positive race-related experiences enhanced a sense of social competence, resilience and psychological well-being, contributing to the ability to cope with subsequent exposure to race-related stressors?

Treatment Implications

Only a few treatment implications will be mentioned here. It is essential that the clinician's attitudes and behaviors convey that he/she can be trusted by the client to address racial issues with genuineness, candor, sensitivity and a non-judgmental attitude (39-40). Particularly in interracial and cross-cultural therapeutic relationships, the clinician's effectiveness depends heavily on building and sustaining the quality of credibility, wherein the client perceives the clinician to possess both the expertise and trustworthiness required to be helpful (55).

One of the first therapeutic tasks is to help create a safe therapeutic environment to even discuss troubling race-related experiences. A concrete therapeutic tactic in this regard is to directly broach the subject with the client. One cannot assume that such will be broached by the client. One clinical strategy is to be forthright about this matter, especially with a client who is of a different race than the clinician and has experienced exposure to severe race-related stressors. The clinician might say: *"As part of our getting to know each other and your background as it relates to why you are in counseling, I want to raise two obvious facts. One, you and I are of different races, and I don't know if that will be something that may hold you back from talking with me about certain experiences. Have you had any positive or negative experiences in trying to discuss sensitive personal matters with other White counselors?"* After this has been discussed, the clinician might continue: *"The very facts that you are an African-American (or.....), and that there has been so much racism in our country, leads to the obvious conclusion that during your life you have been exposed to racism. I know I am stating the obvious, but would that be a fair assumption to make?"*

An additional strategy also is essential to further facilitate the establishment of a therapeutic trust relationship. *"Based on the negative experiences you have had due to racism, I can see where you might not trust someone like me to discuss race-related experiences with. You may be wondering if I really care at all, or if I will be able to understand what you went through? Considering how much racism there is in our country, the fact that I am white, and the fact that we have just met, those are very legitimate concerns and issues to have. Why should you trust me, walking in the door? You have no reason to trust me; indeed, I need to be able to earn your respect and trust. I have been learning that lesson particularly from my many contacts with minority Vietnam veterans over the years.Could you please give me a chance to show you that I do indeed care, and that I may have some understanding as well?"*

Education is essential to help the client to normalize his/her reactions, i.e., it would be abnormal not to have reactions to exposure to significant race-based traumatic events (28, 51-52). In regards to the above racial incident in the latrine, the veteran may be castigating himself that he has continued to have intrusive memories and guilt feelings about the incident. This is an understandable and expectable reaction and he should be clearly told this.

One prototypical PTSD treatment approach is to assist a client to more objectively understand the realities of the race-related stressful experience at the time it happened. Take the example of the African American soldier who had been racially assaulted in the latrine who did not respond overtly. The clinician needs to help the veteran face the realities of the situation at the time it had happened. For example, the reality was that it may have been extremely dangerous to have responded any other way. However, with the passage of time and upon recurring reflections, the client concluded that he "made a mistake by not responding." It may be appropriate to help him understand the legitimacy of his feelings of rage towards the perpetrators, and that he may have redirected rage and helplessness inwardly, punishing himself for "not-responding."

Finally, the nature of race-related stressors requires clinicians to consider environmental intervention functions within a generalist practitioner role, e.g., selected preventive and reform functions directed at the racist milieu (52). For example, intervention at the school system level concerning hostile racist behaviors may be a more effective intervention than clinical support for impacted minority students alone. However, system-level interventions are not the mission of many agencies and clinician may need to consider engaging in selected reform activities (56).

Management of Race-Related Transference and Countertransference

Race-related issues can be emotionally evocative for both clients and clinicians; discussion or avoidance of such may engender significant clinical transference and countertransference dynamics. A clinician/researcher working with any trauma population may manifest two types of countertransference (57-58).Type I reactions involve denial, detachment, emotional distancing or withdrawal from the client. Transference reactions involve the projection of race-based

anger, frustration, resentment or other negative feelings may be particularly problematic for the clinician/researcher, i.e., may result in unduly defensive verbal jousting with the client/subject or feeling the need to defend oneself.

On the other hand, the clinician or researcher may manifest a Type II reaction involving forms of overidentification, enmeshment or overidealization of the client. For example, clinicians with a genuine desire to gain the trust of clients from an historically oppressed racial group, may inadvertently make patronizing comments in an attempt to convince clients (and perhaps themselves) that they are not racist and are opposed to racism. Clinicians may utilize a number of strategies in their endeavors to effectively monitor and manage race-based countertransference reactions (39,40).

Conclusions and Implications

Due to the widespread presence of racist attitudes, behaviors, and obstacles that inhibit careful consideration of the impact of racism, systematic and sensitive inquiry about whether clients have been exposed to race-related stressors should be a routine component of a mental health/research assessment. It is particularly critical with minority clients or when it appears that environmental stressors may be impinging on the client's functioning.

The author is aware of three established psychometric instruments that systematically assess various aspects of exposure to and impact of race-related experiences: (a) the Race Related Exposure Scale developed for Asian American Vietnam veterans (35), (b) The Schedule of Racist Events (10) and (c) The Perceived Racism Scale (59). The paucity and infrequent usage of such instruments contributes to race-related experiences being an unrecognized risk or vulnerability factor. Indeed, race-related experiences may also play a more central role in a range of race-related psychiatric disorders, i.e., there may be race-related PTSD that is solely caused by exposure to race-related trauma (40,44). Finally, what factors may help to transform such negative experiences into more positive outcomes? All of these and related questions beg for systematic clinical and research inquiry.

In conclusion, when one considers the prevalence of racism and the growing evidence of the negative impact on various outcome factors, it seems remarkable that racism and negative race-related behaviors are not mentioned anywhere in the DSM-IV-TR as either (a) psychiatric disorder of someone who is a perpetrator of racist behaviors and attitudes onto others, or (b) risk or etiological factor in adjustment, stress or any other disorders. The silence in DSM-IV-TR about racism and race-related stressors is deafening. The attitudes that underlie such silence may at least partially explain the marked lack of clinical and research attention to the presence and impact of exposure to negative and positive race-related experiences.

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MARY ANN DUTTON, PH.D.

Mary Ann Dutton, Ph.D.

Women encounter many risks associated with intimate partner violence. Health care providers and others who work with these women and their partners often fail to recognize these risks or to respond effectively to them. This increases the danger, not only to women and their partners, but also to their children, family members, friends, and others in the community. The aim of this article is to increase mental health providers' understanding of the risks related to intimate partner violence and to offer guidelines for incorporating that knowledge into their clinical work. This article offers a protocol for use by a mental health professional to overlay on nearly any clinical assessment or treatment approach.

Types of Intimate Partner Violence

Intimate partner violence is a pattern of physical, sexual, psychological, or stalking behaviors. Its severity can range from mild to extreme life-threatening acts. Although intimate partner violence may involve a single incident, more commonly there is an ongoing pattern over time involving various combinations of violent and abusive behavior. The Centers for Disease Control and Prevention, National Center for Injury Prevention and Control in 1999 developed uniform definitions of intimate partner violence for purposes of providing higher quality and timelier incidence and prevalence estimates for surveillance (1). According to these definitions,

- **Physical violence** is defined as "intentional use of physical force with the potential for causing death, disability, injury, or harm" (1, p. 11) and includes pushing, shoving, slapping, beating, hair pulling, hitting with a fist or object, twisting arms, kicking, strangling, using a weapon, and other acts of physical aggression.

- **Sexual abuse** or "abusive sexual contact" is defined as intentional touching of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person against his or her will, or of any person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to be touched (1, p. 12)."

Sexual violence is defined as the use of physical force to compel a person to engage in a sexual act against his or her will (e.g., forcible rape). It also includes attempted or completed sex act involving a person who is unable to understand the nature or condition of the act (e.g., because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure.

- **Threat of physical or sexual violence** involves words, gestures, or weapons to communicate the intent to cause death, disability, injury, physical harm, or to compel a person to engage in sex acts or abusive sexual contact when the person is either unwilling or unable to consent. In addition to direct verbal threats ("I'll kill you"), examples of threats include brandishing a weapon or firing a weapon into the air, gestures, or grabbing for genitalia or breast.

- **Psychological abuse** includes other verbal threats, intimidation, isolation, victim blaming, humiliation, control of daily activities and money, and manipulation of children as a way to abuse the adult partner. Although these acts also occur in dysfunctional, but non-violent, relationships, they are considered psychological abuse when they occur in the context of prior physical or sexual violence.

- **Stalking** is a more recently recognized pattern of behavior that involves repeated unwanted contacts such as phone calls, letters or notes. It may include repeatedly showing up at work or outside one's home, often remaining there for long periods. Stalking is not included in the CDC's taxonomy, but has been well documented as surprisingly common within intimate relationships (2).

The remainder of this article discusses specific guidelines for addressing domestic violence in mental health clinical practice. Alarmingly, mental health professionals often fail to recognize indications of intimate partner violence, even when they are apparent and, even more often, neglect to include it in their assessment procedures. The protocol offered here provides guidance in order to (1) routinely screen for intimate partner violence, (2) assess for danger of serious and lethal violence, (3) assess for other types of batterer-generated risks, (4) assist with safety planning, and (5) document IPV in the clinical record.

NEW DIRECTIONS

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National Center Collaboration with the U.S. Military

Reviewing National Center programs over the years, it is clear that there have been a growing number of joint projects with colleagues in the Department of Defense (DoD). There are two major reasons for this, one scientific and clinical while the second is due to a change in policy.

Short of preventing war, rape, natural disasters, etc., from a scientific and clinical perspective, the best approach is to identify populations that will definitely be exposed to extreme stress and to follow them longitudinally before, during, and after their traumatic experiences. This is the scientific context for our growing number of collaborations with colleagues in DoD since men and women in the U.S. military constitute a population that can be expected to be exposed to severe, and sometimes traumatic, stress during the course of their military careers. Such a strategy makes it possible to detect personal or experiential factors that may be associated with resilience or vulnerability. We know that some people are more resilient than others because the majority of people exposed to traumatic experiences do not develop PTSD. Other people are more vulnerable since they will develop PTSD following experiences with which their peers have coped successfully.

Therefore, collaborative projects with DoD provide an excellent opportunity to understand the stress-induced psychological and psychobiological alterations that may precipitate PTSD among vulnerable individuals. By understanding these mechanisms we can hope to develop clinical techniques for early detection to individuals at risk, for preventive strategies to fortify resilience among all active duty personnel, and for clinical interventions for military personnel experiencing severe post-traumatic distress.

At the policy level, the growing number of collaborations with military colleagues is emblematic of the closer cooperation and collaboration between DoD and VA that has characterized the post-Gulf War era. DoD respects the scientific and clinical expertise of VA concerning PTSD with the hope and expectation that some of this information may be useful in enhancing resilience and coping skills of active duty men and women exposed to severe stress in the line of duty. VA, recognizing that military personnel of today are the veterans of tomorrow, supports these initiatives with the hope that early detection and intervention may prevent future veterans from developing stress related disorders in the first place.

In this context, I would like to mention several National Center investigators who are currently engaged in groundbreaking research focused on military personnel.

Brett Litz PhD, at the Behavioral Sciences Division, has carried out rigorous investigations of psychological distress among American men and women deployed on UN Peacekeeping missions in Somalia, Bosnia, and Kosovo.

Andy Morgan MD, at the Clinical Neurosciences Division, has identified fundamental alterations in biological mechanisms involving cortisol, testosterone, neuropeptide Y and other key systems among military trainees exposed to the uncontrollable stress of a mock captivity at Fort Bragg.

Erica Sharkansky PhD, at the Women's Health Sciences Division (continuing work begun by Jessica Wolfe and Marie Caulfield), has investigated resilience and vulnerability among female recruits at the U.S. Marines' Parris Island Training Center.

Julia Whealin PhD, at the Pacific Islands Division (along with Andy Morgan MD and Paula Schnurr PhD, at the Executive Division), has worked closely with Wayne Batzer MD at Tripler Army Medical Center in Honolulu to investigate resilience and vulnerability among active duty forces deployed throughout the U.S. Pacific Command.

Patricia Watson PhD, at the Executive Division, and Josef Ruzek PhD and Bruce Young, LCSW, at the Education Division, have participated in an acute combat stress education and consultation network involving DoD personnel stationed throughout the U.S. and in Germany, Bosnia, and Kosovo. This program is led by Col. Jim Stokes MD from Fort Sam Houston, with major participation by LTC E. Cameron Ritchie MD at the Pentagon.

Paula Schnurr PhD, LTC Charles Engel MD, at Walter Reed Army Research Institute, and I were recently funded to conduct a twelve site VA Cooperative Study testing the efficacy of cognitive-behavior therapy (prolonged exposure) for female veterans and active duty personnel. In addition to eight VA hospitals and two Vet Centers, two DoD sites will be included. The DoD sites are Walter Reed Hospital in Washington, DC and Tripler Army Medical Center in Honolulu, HI.

I have described our most important DoD collaborations that are currently underway, although there are other projects concerning educational, consultative, and research initiatives with DoD colleagues at the Pentagon and the Uniformed Services University of the Health Sciences. These will be described in future columns as they move from the drawing board to the implementation phase.

We look forward to continuing to work more closely with our DoD colleagues and believe that we all have much to learn and even more to gain from these collaborative projects.

WOMEN AND TRAUMA: A CLINICAL FORUM

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Training for Sexual Assault Counselors, Part I: Identifying the Science-Practice Gap

Annabel Prins, Ph.D. and Tracy L. Fleming, B.A.

The statistics are alarming: Over 12,000,000 women have experienced a completed rape during their lifetime (1-2). Although most victims of rape will never report their experience to the police, many will receive services from a trained sexual assault counselor. Indeed, most emergency rooms have treatment protocols for victims of rape that includes the presence of a sexual assault counselor, and most communities have rape crisis "hot lines" that are staffed by sexual assault counselors. Without question, sexual assault counselors are often the first and only source of emotional support for sexual assault survivors.

Nationwide, there are more than 1,000 rape crisis centers, many of which were established in the 1970's in response to the women's movement (3). In most states, individuals interested in becoming a sexual assault counselor are required to participate in formal training. This typically includes at least 40 hours of classroom and one-to-one instruction on the sociocultural, medical and legal aspects of sexual assault, as well as basic principles of crisis intervention (e.g., stabilization and validation). A core part of the training is to review the consequences of sexual assault and to understand how "rape myths", secrecy, and negative coping (e.g., drinking) interfere with recovery. These points of emphasis are similar to those recommended in clinical "guidelines" for the prevention and treatment of PTSD (4-5) . Indeed, these guidelines specify that early interventions should focus on normalizing reactions to traumatic events (i.e., psychoeducation about trauma and post-trauma reactions), relieving irrational guilt (i.e., challenging beliefs about rape and recovery), and encouraging disclosure (i.e., knowing who to disclose to as well as when and what to disclose). These are clearly activities that can be, and often are, delivered by rape crisis counselors.

In order to further examine the overlap between clinical guidelines and the training and practice of sexual assault counselors, we reviewed eighteen randomly selected rape crisis training manuals (6). With regard to psycho-education, all of the manuals gave considerable attention to the nature and prevalence of rape although several recent and large-scale studies on the nature and prevalence of post-traumatic reactions were often omitted (2). All of the manuals included coverage on the rape trauma syndrome, first studied and articulated by Burgess and Holstrom in 1974 (7). This syndrome emphasizes two stages: the acute stage in which the survivor's life is completely disrupted and the long-term process stage in which the survivor begins to re-adjust and re-organize her life. Although common reactions to trauma (e.g., nightmares, avoidance) were always included in these descriptions, no information was provided on the percentage of survivors struggling with these reactions over time. Such information is now available and important for being able to normalize a survivor's reactions (8). Furthermore, rather than specific stages, adjustment to trauma appears to fall into different response clusters (i.e., re-experiencing, avoidance, numbing, hyperarousal) and to follow a dynamic pattern (9). For example, periods of active avoidance and withdrawal are often followed by periods of intrusion and re-experiencing. Finally, most of the manuals did not provide information on different therapies or therapy approaches and few reported on the recovery process itself (i.e., "natural course" of symptoms) as well as the effectiveness of different interventions for reducing PTSD symptoms (10).

All of the manuals provided excellent coverage on frequently held beliefs or myths about rape and most provided strong counter-arguments for these beliefs. Missing, however, was information on how to determine if a survivor held a particular belief and how to challenge these beliefs in a constructive and empowering way. In addition, little emphasis was given to destructive beliefs about immediate reactions to the assault (e.g., "I am going crazy") as well as beliefs about personal power and ability to cope (e.g., "I can't do anything to help my situation").

Finally, all of the manuals recognized the importance of disclosure. A few provided information on what to expect when sharing one's experience and many provided information that could be given to friends or family members. Some of the manuals also encouraged disclosure in the form of writing or "journaling" but none provided information on when disclosure might be indicated nor the importance of repeated disclosure of both feelings and facts (11).

It would appear, then, that despite similar goals, there are significant differences between recommended clinical practices and the training provided to rape crisis counselors. Some of these differences may reflect divergent historical traditions and/or different perspectives on trauma and helping. For example, a strong commitment on the part of rape crisis centers to emphasize the criminal nature of rape and the societal forces that promote or excuse such a crime, as compared to a clinical focus on the individual and the

Suggested Protocol for Working With Intimate Partner Violence Victims

1. Routinely Screen for Intimate Partner Violence

Routine screening for intimate partner violence is recommended as an essential protocol for all health care providers, including mental health professionals (3). Since intimate partner violence can occur in relationships of all types, across all ages, and among persons of all socioeconomic, ethnic, and educational backgrounds, there is no reliable way to detect intimate partner violence other than to routinely and universally screen for it. Routine screening to identify potential victims can be incorporated into a clinical intake protocol. A screening protocol recommended by the Family Violence Prevention Fund's Health Initiative (4) suggests that, at minimum, screening a) should be part of a face-to-face health care encounter, b) be direct and nonjudgmental, c) take place in private, d) be confidential, and e) should use interpreters, rather than patient's friend of family members, when necessary. The Fund further suggests that the screener should indicate that the protocol is routine, since violence is so common, and that it arises out of a concern for patients' safety and well-being.

2. Assess for Danger of Serious or Lethal Violence

Just as threat assessment of potentially dangerous patients is an ethical and moral obligation of mental health professionals, danger assessment is similarly important when working with victims of intimate partner violence. There is a growing body of research literature identifying risk factors associated with serious or lethal domestic violence (5, 6). Below is a brief discussion of several key risk factors useful for guiding clinical risk assessment in situations involving intimate partner violence.

Prior history of domestic violence. Recent escalation of frequency or severity of violence or abuse has been associated with increased risk of lethal violence (5).

Relationship estrangement or separation. Research has shown that separation or estrangement is a precursor to a significant proportion of domestic homicide cases (7, 8).

Violation of court orders, including violation of orders of protection. Violation of a current order of protection was found in 81% of domestic homicide cases in New York and violation of a former order of protection in 70% of such cases.

Obsessive possessiveness or morbid jealousy. Obsessive possessiveness or morbid jealousy (9), also termed "sexual proprietariness" (10), has been found in approximately 50% of domestic homicide cases.

Threats to kill. Prior threats to kill have been found as a precursor in nearly 50% of domestic homicide cases (7).

Suicidality. Domestic violence perpetrators' suicidality has been a recognized risk factor for domestic homicide (11). Implications for screening depressed or suicidal patients are obvious.

Alcohol and substance abuse. A substantial proportion of domestic homicide perpetrators (and homicide victims) have been found to have an alcohol or substance abuse history or both (7).

Extreme minimization / denial of domestic violence. Minimization and denial of having engaged in domestic violence has been associated with increased risk for violent recidivism (12).

Stalking. Stalking refers to "a combination of activities that batterers do to keep the connection between themselves and their partners from being severed (13, p. 142)" and is recognized as a risk factor for increased risk of serious domestic violence (12).

Abuse toward children. There is an overlap of abuse toward children and toward their mothers (14). Violence toward children can be a means of abuse to their mothers when the abuser no longer has access to her or simply wants to punish or intimidate her. In a recently publicized case, one estranged father, prior to shooting his two young children while they were strapped into their car seats, signed them out from school, citing as the reason, "to get back at their mother."

Excessive Control. Control of most or all of a woman's daily activities can signal a high level of risk (5). Some women describe that their partner monitors the odometer on their automobile, listens to their phone conversations, or even will not allow them to talk to certain people, especially to other men. Other victims have been made to account for every minute of their time or to remain by the phone continuously so that they will be available if their partners call.

3. Assess the Matrix of Other IPV-Related Risks

Victims of intimate partner violence face ongoing risks from their abusive partners, regardless of whether the couple has separated, even when they have terminated their relationship. Davies (15) and her colleagues have identified seven categories of "batterer-generated risks" associated with female victims, which may be relevant for male victims as well. Each of these types of risk can exist if women have left an abusive relationship as well as if they choose to remain. A brief discussion of each of these risk categories follows.

Physical harm. There exist risks of physical harm other than death or serious physical injury. Intimate partner violence has been associated with a range of physical conditions and symptoms, including migraine headaches, gastrointestinal problems, lower back pain, and other stress-related illnesses (16). In some cases, batterers abuse their partners by controlling their prescribed medications or access to necessary health care.

Psychological harm. Women who are repeatedly abused experience greater depression and stress than those for whom the violence ceases (17). Battered women are at increased risk of suicidality (18). Thus, women who remain in an abusive relationship risk serious or ongoing psychological damage.

Children. Children are a critical component in the matrix of batterer-generated risks. Children themselves are at risk of being harmed when they attempt to intervene in ongoing violent incidents, when they are unintentionally injured during an assault, or when an abuser turns his fury toward them – perhaps as a means of hurting their mother. Children are also at risk when custody and visitation become a fertile battleground for the abuse of power and control often observed in abusive relationships.

Legal. Women face legal risks when their abusive partners engage in illegal activity in their presence (e.g., drug dealing) or involve them in it directly (e.g., riding in a car used in a theft). Women on probation may be threatened with jail or severe fines by their abusive partner's threats to report them for false charges.

Financial. Abusive partners can create credit problems by exploiting their partners' credit worthiness, such as when they insist on using cards that are only in her name. Financial strain also occurs when an abusive partner destroys a woman's possessions, especially when she has few resources to replace them or when they are extraordinary losses (e.g., burning down the house, destroying the car). Finally, women encounter untold financial losses due to lost wages resulting from injury or interference with employment or education.

Family or friends. Women encounter risks to family or friends when their abusive partners' threaten or harm them – especially as a means of controlling their partner. Family or friends who assist a woman in leaving are especially vulnerable. Threats or harm to family members may serve as a proxy for violence to the abused woman when the abuser can no longer access her when she separated or is hiding from him.

4. Engage the Battered Victim in Safety Planning

Safety planning is a skill-building process more than it is an outcome or a product. Battered women typically have developed well-honed skills in their attempts to keep themselves and their children safe. Nevertheless, making the process explicit can be clarifying, since it allows a victim to reflect, taking a step back from the usual immediacy of the situation. Safety planning is a process that anyone working with persons at risk for IPV should incorporate into their routine clinical work. It is essential for the mental health professional never to assume he or she has the key to understanding how any individual battered victim can be or remain safe. Rather, they provide a framework with which to assist the victim who have been battered with the process.

When a mental health care professional has identified, through a universal screening protocol or some other means, someone who has experienced actual or threatened intimate partner violence, safety planning should be begin within the same contact. Safety planning begins with a discussion of the level of risk, integrating the victim's own subjective appraisal of risk with the clinician's assessment of risk factors. Next, a review of strategies previously attempted and their consequences can provide a map of the victim's experience of what has worked in the past and what has not, including what has made the situation more dangerous. Finally, safety planning also focuses on the development of strategies for specific situations (e.g., for work, for home when the abusive partner has left, for home when the abusive partner is still in the home) at specific points in time (e.g., following the criminal court hearing or divorce decree, when transferring the children for purposes of visitation). A safety plan is not a contract with the clinician, since it may need to be altered at a moment's notice as circumstances change. It is a way of thinking and should be revisited at every contact with the patient.

5. Document Information about IPV

Documenting domestic violence in a medical record is important for several reasons, although it is not without risks. Continuity of care is enhanced when health care providers have knowledge of prior intimate partner violence and related information. Such records can be important in litigation, such as in divorce and custody cases as contemporaneous corroboration of abuse allegations and associate damages. The recent issuance of final regulations on medical records privacy in Congress provides a level of privacy not previously available to domestic violence victims, the lack of which has contributed to the denial of various types of insurance to battered women.

Conclusion

Working with persons who have already been injured by intimate partner violence is not enough. Mental health professionals have the opportunity to engage routinely in secondary prevention. Countless children could have been prevented from witnessing the murder of one parent and sometimes the accompanying suicide of the other, or from being killed along with their mother. Intimate partners who have been killed could have been saved had there been resources provided to protect victims. Retrospective domestic homicide death reviews often reveal that the community and legal systems that could have offered help failed to do so. Mental health professionals can and should do more – they can routinely engage in secondary violence prevention. These guidelines have been offered toward that end.

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The *NC-PTSD Clinical Quarterly* is available for free to readers employed by the Department of Veterans Affairs. Non-VA employees can receive the *Clinical Quarterly* at nominal cost by using the Superintendent of Documents form below. Selected articles are also available for free in PDF format from our website: **www.ncptsd.org**

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NATIONAL CENTER FOR PTSD CLINICAL TRAINING PROGRAM

The Education and Clinical Laboratory Division for the National Center for Post Traumatic Stress Disorder at the Palo Alto CA VAMC, in collaboration with the VA Employee Education System, offers a Clinical Training Program (CTP). The training program is approved for 30 Category 1 CEUs for physicians, psychologists, social workers, and nurses.

Each year we welcome many mental health professionals from across the United States and from around the world. Most clinicians who enroll in the program have a working knowledge about treating the effects of trauma and PTSD and are looking to upgrade their clinical skills. The CTP offers a broad range of educational activities, including:

* **Lectures**
* **Clinical consultation**
* **Clinical observation of group treatment**
* **Group discussions facilitated by staff**

Specific training topics include warzone trauma group treatment, treatment of women veterans, treatment of sexual assault related PTSD, relapse prevention, cross cultural treatment issues, assessment and treatment of families, disaster mental health services, cognition and PTSD, assessment of PTSD, and psychiatric assessment.

Training programs are scheduled for a minimum of one week, though longer programs are available if the applicant can justify an extended stay. Programs are scheduled nine times per year, on the second or third week of the month.

Funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or VA Employee Education System.

For more information, or to request an application, please email:
Josef.Ruzek@med.va.gov
or telephone FTS 700-463-2673; commercial number 650-493-5000, ext. 22673.

symptoms or disorder she may have. We believe that the clinical research conducted in the last 10 years on PTSD and its treatment has a lot to offer sexual assault survivors and that this information can be presented within a model of personal empowerment. The education division of the National Center for PTSD in collaboration with the California Coalition Against Sexual Assault is currently providing such a training to a number of diverse rape crisis centers. Part II of this column will report on the outcome of these training activities from the perspective of the sexual assault counselors who have participated.

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MONTHLY MENTAL HEALTH CRISIS COUNSELING CONFERENCE CALLS

The National Center for PTSD and Readjustment Counseling Service co-host a teleconference call to facilitate networking and information sharing for **VA practitioners** and **American Red Cross** volunteers interested in disaster mental health. Calls are scheduled the first Thursday of each month, 11:00am (EST).

Schedule for 2001

Jan 4	800-230-2150	Jul 5	800-230-2250
Feb 1	800-230-2250	Aug 2	800-230-2250
Mar 1	800-230-2250	Sept 6	800-230-2250
Apr 5	800-230-2250	Oct 4	800-230-2250
May 3	800-230-2150*	Nov 1	800-230-2250
June 7	800-230-2250	Dec 6	800-230-2250

* Note different phone line for May

Request operator to be connected to the "Mental Health Crisis Counseling call."

Past speakers have been affiliated with VA Central Office, VA Medical Centers, Readjustment Counseling Service, American Red Cross, Department of Defense, the private sector and have included:

Laurent Lehmann, M.D.	Joe Gelsimino, Ph.D.
Bruce H. Young L.C.S.W.	Teri Elliot, Ph.D.
Patricia Tritt, R.N.	Judith Lyons, Ph.D.
John Tassey, Ph.D.	Dusty Bowencamp, R.N.
Joe Sivak, M.D.,	Mark Dembert, M.D.
James Munroe, Ph.D.	Paul Ofman, Ph.D.
Karen Sitterle, Ph.D.	John Whitten, M.S.W.
John Weaver, M.S.W.	Bruce Crow, Ed.D.
Francis Abueg, Ph.D.	Jerry Jacobs, Ph.D.
Greg Burham, M.S.	Randall Quivilan, Ph.D.

For futher information, please call:
Bruce H. Young, L.C.S.W.
Disaster Services & Training Coordinator
National Center for PTSD
650-493-5000 ext. 22494.

NATIONAL CENTER FOR PTSD EDUCATION, TRAINING, & SUPPORT SERVICES

PTSD Assessment Library

Available upon request are selected instruments from our library of assessment and program evaluation tools (with accompanying articles), together with templates describing over 100 trauma-related measures courtesy of Beth Stamm, Ph.D., and Sidran Press. Telephone (650) 493-5000 ext. 22477.

PTSD Article Library

A helpful set of key articles on aspects of PTSD is available to VA or Vet Center clinicians free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Video Library

The Menlo Park Education Team maintains a small videotape lending library exploring topics related to PTSD diagnosis, evaluation, and treatment. Videotapes may be borrowed free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Program Liaison and Consultation

The Menlo Park Education Team can help VA health care professionals locate needed resources. Services may include assistance in locating relevant articles, locating resource persons, or problem-solving. Staff are available to consult in the areas of PTSD Diagnosis and Treatment, Program Development and Design, Women and Trauma, Relapse Prevention, and with other PTSD-related concerns. Telephone (650) 493-5000 ext. 22977.

National Center for PTSD Web Page

The NC-PTSD Home Page provides a description of activities of the National Center for PTSD and other trauma related information. The world wide web address is: *http://www.ncptsd.org*

PILOTS Database

PILOTS, the only electronic index focused exclusively on the world's literature on PTSD and other mental health consequences of exposure to traumatic events, provides clinicians and researchers with the ability to conduct literature searches on all topics relevant to PTSD. *http://www.ncptsd.org/PILOTS.html*

NC-PTSD Research Quarterly

The *Research Quarterly* reviews recent scientific PTSD literature. Telephone (802) 296-5132 for subscription information.

Disaster Mental Health Training and Consultation

Education staff provide training in disaster mental health services, including team development, interfacing with other agencies, on-site and off-site interventions, debriefing, and psychoeducational and treatment interventions with disaster survivors and workers. Telephone (650) 493-5000 ext. 22494 or email: *bruce_young_ncptsd@hotmail.com*

Conferences and Training Events

The Menlo Park Education Team provides consultative support for the development of training in PTSD. Services include assistance in finding faculty and designing program content. Telephone (650) 493-5000 ext. 22673.